Patient Screening Form

Staff screener: _____ Patient Name: _____

Date: _____

	Pre-Screen	In-Office
Have you had COVID-19? If yes, when…. _____	YES NO	YES NO
Have you been in contact with any confirmed COVID-19 positive patients, or persons self-isolating because of a determined risk for COVID-19?	YES NO	YES NO
Have you quarantined for 14 days, if you needed too?	YES NO	YES NO
Do you have a fever or have felt hot or feverish anytime in the last two weeks? Patient temperature at appointment:	YES NO	YES NO
Do you have any of these symptoms: Dry cough? Shortness of breath? Difficulty breathing? Sore throat? Runny nose?	YES NO	YES NO
Have you experienced a recent loss of smell or taste?	YES NO	YES NO
Have you returned from travel within Canada from a location known affected with COVID-19?	YES NO	YES NO
Have you returned from travel outside of Canada in the last 14 days?	YES NO	YES NO
Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder?	YES NO	YES NO